Employer Medical Service Order

Doctor / Clinic Name:____

Doctor / Clinic Address:____

We are sending ____ to you for an
(Employee Name)

evaluation relative to a work-related injury sustained on: ____
(Date of Injury)

Please submit your Doctor's First Report of Injury and any subsequent medical reports and bills to:

CompWest Insurance Company
PO Box 40790
Lansing, MI 48901
Or fax to: 866-506-5800 or 517-316-2747
Telephone: 714-641-9500 or 888-266-7937

Employer Name: ____

Signature: ____

Print Name and Title: ____

Phone Number: ____

Please be advised we make every effort to accommodate modified/light duty.

Please be specific as to the weight, frequency and duration of those activities.

CompWest Insurance Company is a member of AF Group. All policies are underwritten by a licensed insurer subsidiary of AF Group.